First Steps
Evaluation/Progress Report

Name: DOB: First Steps ID#:

Chronological Age: Adjusted Age:

Treating Diagnoses and ICD9 code(s):

Onset Date:

Precautions/Contraindications:

IFSP Date:

Date of first treatment:

Attendance this period:

PCP and contact information:

Report Date:
Discipline(s):

Report Type:

- ☐ Evaluation
- ☐ Initial – Q1
- ☐ Quarter 2
- ☐ Discharge
- ☐ Quarter 3
- ☐ Annual -- Q4
- ☐ Other:

Team Information

Family Information

Parent / Guardian Name:

Address:

Phone:

Email:

Provider Information

Service Coordinator: Email:

ED Team Lead: Email:

Team Members-- including all providers and ED Team members (list reporting provider first):

Services

First Steps services (add lines as needed)

Treatment Order/Services: Treating Diagnosis:

Frequency: Session length: Duration:

Treatment Order/Services: Treating Diagnosis:

Frequency: Session length: Duration:

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Additional services

IFSP Goals/Outcome Review

Functional Status:

Discharge Goal:

Long Term Goals (IFSP Outcomes):
Outcome #

Outcome #

Outcome #

Short Term Goals:
#
Date set: Expected Resolution: Status:
Baseline:
Current Level:

#
Date set: Expected Resolution: Status:
Baseline:
Current Level:

#
Date set: Expected Resolution: Status:
Baseline:
Current Level:

Additional Notes:

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Name: DOB: First Steps ID#:

_____ _____ Date:
Therapist Name Therapist Signature

_____ _____ Date:
Therapist Name Therapist Signature

_____ _____ Date:
Therapist Name Therapist Signature

Therapists are to review this progress report with the parent/caregiver and provide them with a signed copy. Date copy of this report was shared / will be shared with parent/caregiver:

Physician Plan of Treatment

I certify that continued treatment for_____ as outlined by the **IFSP** is necessary for the proper treatment of this patient.

Physician: Date: